# *Child – youth information sheet*

***Please complete one form for each child/adolescent. Have teens (12-18) complete the form themselves. Your answers below are confidential. Please ask any questions you have in completing the form.***

TODAY'S DATE __________ NAME ____________________________________________

DATE OF BIRTH _________ AGE ________ PARENT/GUARDIAN ____________________

| ***Address (home)*** | ***Phone Numbers*** | ***May I leave a message?*** | |
|---|---|---|---|
| STREET ______________________________ | DAY ________________ | YES | NO |
| CITY/STATE/ZIP ________________________ | EVE ________________ | YES | NO |
| EMAIL _______________________________ | CELL ________________ | YES | NO |

SCHOOL ATTENDING __________________________________ GRADE ____________

TEACHER OR SCHOOL COUNSELOR NAME ______________________________________

MEDICAL INSURANCE COMPANY ___________________________ PHONE _____________

SUBSCRIBER ID #_______________ INSURANCE CONTACT PERSON__________________

PRIMARY CARE PHYSICIAN_____________________________________________

PHONE _____________________________ DATE OF LAST EXAM _________________

DO YOU CURRENTLY SEE A PSYCHIATRIST? (circle one) YES NO

IF YES, NAME _________________________________ PHONE__________________

MAY I CONTACT YOUR PHYSICIAN(S) IF NECESSARY (circle one) YES NO

YOUR SIGNATURE (indicating your consent) _____________________________________

PLEASE LIST ANY HEALTH PROBLEMS FOR WHICH YOU CURRENTLY RECEIVE TREATMENT OR HAVE RECEIVED TREATMENT FOR IN THE PAST

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

LIST ANY MEDICATIONS (prescription and non prescription) THAT YOU ARE CURRENTLY TAKING:

| TYPE | DOSE | REASON |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

WHO REFERRED YOU TO ME? ________________________________________________

Confluence
*family therapy*

# *Child – youth information sheet*

PREVIOUS COUNSELING/THERAPY (circle one) YES NO

DATES ____________________ THERAPIST'S NAME ______________________________________________

____________________ ______________________________________________

____________________ ______________________________________________

WHAT WAS HELPFUL OR NOT HELPFUL ABOUT ANY PREVIOUS COUNSELING/THERAPY?

______________________________________________________________________________

______________________________________________________________________________

***Please indicate the current use and frequency of the following substances***

| | more than once a day | once a day | once every 2–3 days | weekly | monthly | yearly or less | never |
|---|---|---|---|---|---|---|---|
| alcohol | | | | | | | |
| non-prescription drugs | | | | | | | |
| prescription drugs | | | | | | | |
| nicotine | | | | | | | |
| caffeine | | | | | | | |

HOURS OF SLEEP PER NIGHT __________________ BEDTIME ______________________________

WHAT KINDS OF FOODS/DRINKS DO YOU YOU HAVE MOST OFTEN? ______________________

______________________________________________________________________________

______________________________________________________________________________

ANY CONCERNS ABOUT EATING HABITS OR NUTRITION ______________________________

______________________________________________________________________________

HOW OFTEN DO YOU EXERCISE? __________ TIMES PER WEEK (circle one) DAY WEEK MONTH

WHAT TYPES OF EXERCISE DO YOU ENJOY? ____________________________________________

______________________________________________________________________________

HOW DO YOU SPEND YOUR TIME WHEN YOU ARE NOT WORKING? WHAT KINDS OF ACTIVITIES AND HOBBIES ARE YOU INVOLVED WITH? ______________________________

______________________________________________________________________________

______________________________________________________________________________

WHO ELSE LIVES IN YOUR HOUSEHOLD? WHAT IS THEIR RELATIONSHIP TO YOU?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

# *Child – youth information sheet*

ARE PARENTS/GUARDIANS SEPERATED OR DIVORCED? (circle one) YES NO

If yes, please list the contact information of the other parent/guardian

NAME ______________________________ HOME # ______________

ADDRESS ______________________________ WORK # ______________

______________________________ CELL # ______________

DO THE PARENTS/GUARDIANS SHARE JOINT CUSTODY? (circle one) YES NO

If sharing time in two homes, please explain the current living arrangements/visitation scedule

______________________________

______________________________

______________________________

EMERGENCY CONTACT ______________________________ PHONE ______________

RELATIONSHIP ______________________________

PLEASE STATE THE REASON(S) WHY YOU ARE SEEKING COUNSELING AT THIS TIME

______________________________

______________________________

______________________________

______________________________

PLEASE LIST ANY COUNSELING GOALS YOU HAVE ALREADY IDENTIFIED

______________________________

______________________________

______________________________

______________________________

HOW MANY SESSIONS DO YOU THINK IT MIGHT TAKE TO ADDRESS YOUR CONCERNS? ________

***With respect to the Health Insurance Portability and Accountability Act (HIPAA), the regulations regarding Protected Health Information (PHI) were provided to me by Confluence Family Therapy.***

______________________________ ______________

SIGNATURE DATE

______________________________ ______________

PARENT/GUARDIAN SIGNATURE (for youth under 13) DATE

*thank you.*